

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Friday, September 10, 2004

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
FRANCIS J. CROSSON, M.D.
AUTRY O.V. DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Public comment

MR. FENIGER: You always preface it with brief, after lengthy and interesting discussions.

MR. HACKBARTH: And when you get up I say really brief.

MR. FENIGER: Because you've heard this before.

Randy Feniger with the American Surgical Hospital Association and, of course, I would like to comment on the beginning discussion of the work so far on the MMA assignment.

Congratulations to the staff for what I thought was a very well done presentation about a very complex issue. And I was also very impressed by the depth of the discussion of the members of the Commission. You obviously have given a lot of thought to this and recognize that this is not a slam dunk one way or the other. There are many complex issues. And I think certainly as an industry we appreciate that.

We had very positive feedback from our own members who were visited in the site visits, in terms of their interaction with the staff. So I think that simply reflects upon the quality of your staff, the way they handled themselves out in their site visits. And they would be welcome back, which is not always what we say about government officials.

Some points I would like to have you keep in mind as you go forward in your consideration. A good bit of discussion about self-referral and the potential for conflict. I would only say what about the conflicts created when a hospital employees physicians or owns medical practices? There are silly pressures there to make referrals, to make judgments. I think we have to be extremely careful in if we're going to look at one, we look at all of them to try to sort that out.

The issue that was raised in a number of comments, trying to analyze in a community the impact of a hospital, especially the hospital opening, and change in procedure level or capacity. What benchmark do you use to evaluate that change as either positive or negative?

I think that's going to be very, very important because an individual community may not be providing adequate amounts of heart care or orthopedic care. The specialty hospital adds to that. I'm not saying that's true in every case. But I think that the benchmark you use for the basis of your judgment will be important.

Most of this focused on investors. I would encourage you and encourage the staff to take a look at those physicians -- and perhaps they have and it was just not discussed as much. There are on average three times as many physicians with attending privileges at these hospitals as there are investors.

So obviously, there's something attractive about this model for other physicians who haven't put a nickel into the system. I think it's important that you understand that as a Commission, that the staff develop that to the extent that they are able to, because I think it goes right to the heart of whether this is driven simply by a financial issue or it's driven by other more complex issues related to physician efficiency, patient quality, et cetera, et cetera. The point was made that heart hospitals are the dominant Medicare provider in terms of a number of patients but they are not the dominant model in the industry. We have 71 member hospitals. Only five are cardiovascular hospitals. All of the others are mixed surgical hospitals. They provide, on average, six surgical specialties in their service mix.

So I would be concerned, and hope you would be cautious, about making decisions that

affect everybody based on the heart model alone. It is a different kind of hospital and I don't mean this in any way critically. It is simply not the style of hospital that we see across the country that most physicians are involved in.

Also, the stories behind these, the point was made -- I'm not sure which commissioner made it -- that these companies come and hunt for investors in sort of build it and they will come theory. Most of these hospitals arise out of conflict between medical staff and hospitals. And then physicians, because they can't resolve it, rightly or wrongly, then may turn to an investment group or corporation to develop an alternative solution.

I think those stories may be important, perhaps a good lesson for hospital management graduate programs.

Financial impacts on community hospitals, as was discussed, are multifaceted. Isolating the specialty hospital is the cause of financial change in an individual institution or group of institutions, I think is going to be very, very tricky. I think it's very easy, if your money isn't doing quite what you want it to as a hospital, to say well, it's that specialty hospital across town. I was fine until then. But we heard that about for-profit hospitals 20 years ago. We heard that about ASCs 20 years ago. We still have hospitals in business. So I'd be a little careful on that.

The rural issue is an important one. There are not a lot of hospitals. I have been told, and this is anecdotal, by people in rural communities, the presence of the specialty hospital is often a tool to recruit additional specialists who would not otherwise be willing to come to that community. And that may be something that, to the extent the staff is able to look at the rural issues at all, they might want to get behind that and see has it actually improved the quality of care.

And finally, I think you really hit on the debate towards the end and then the second discussion after that really got into it. This is an issue about the correctness or the accuracy of the payment system. Hospitals use subsidies to pay for things.

To the extent that we, as a society, agree community hospitals provide social goods that we want, we should be prepared to pay for them. If we are not paying for them accurately, I would think that should be the focus of the ultimate analysis. I realize you have to make a report on specialty hospitals.

But I think the issues as you got into them in both your discussions are much broader and I think we would very much welcome a debate over the quality and accuracy of the reimbursement system, as opposed to whether competition should be allowed to develop in any given community under state or federal law.

Thank you.

MR. HACKBARTH: Okay. Thank you, very much.